Care Coordination: Behavioral Health
Providers and Health IT Readiness

Case Studies Data
September 2013

OVERVIEW

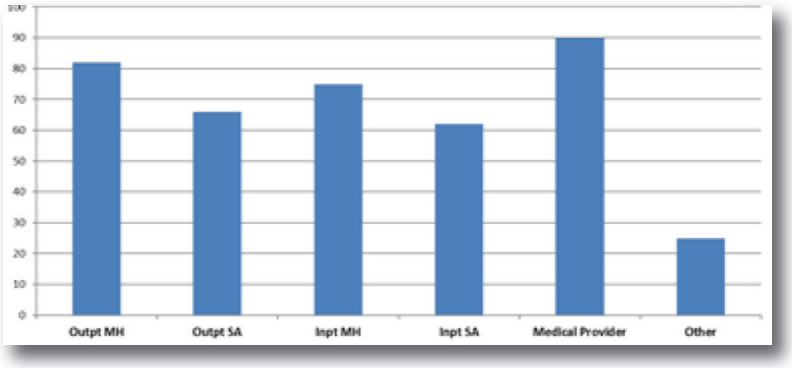
Transitioning to electronic heath records, and ultimately connecting to the health information exchange, furnishes the foundation to care coordination, allowing providers to consult instantaneously on a patient's record and develop an integrated care plan addressing one or more specialty care areas.

Behavioral health providers play a central role in care coordination and through the Affordable Care Act have been granted parity to medical providers to receive coverage by all carriers of health insurance. However, such equity did not carry to the incentive dollars for electronic health record (EHR) adoption and by all measures these providers have received a fraction of investment for these purposes.

Despite the disparity of incentive dollars, Illinois' experience over the last two years shows that behavioral health providers are engaged and, moreover, forging a trail in adopting tools of health information technology (health IT) and participating in electronic exchange of records. And, they are even recipients of incentive dollars.

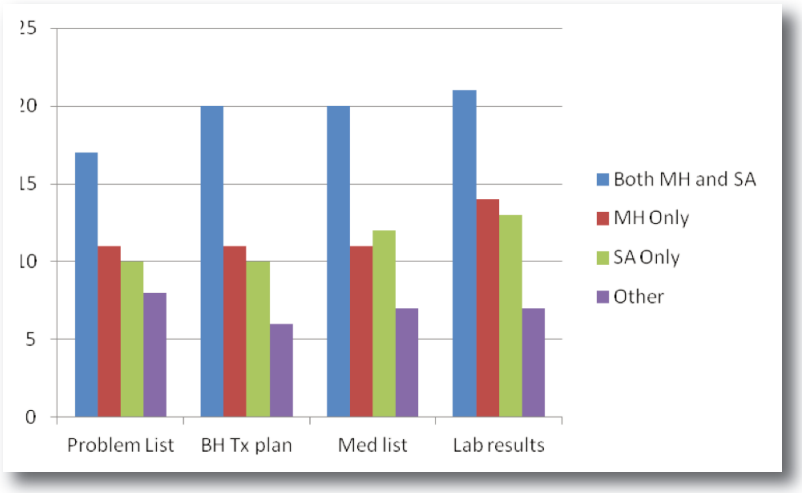
Two surveys conducted in 2012 by the Illinois Health Information Exchange shed light on the progress that behavioral health providers are making in Illinois. These Case Studies Data provide a snap shot of behavioral health providers as their commitment to health IT grows – despite the challenges.

Medical providers are typically one of the primary exchange partners for behavioral health providers in care coordination today.



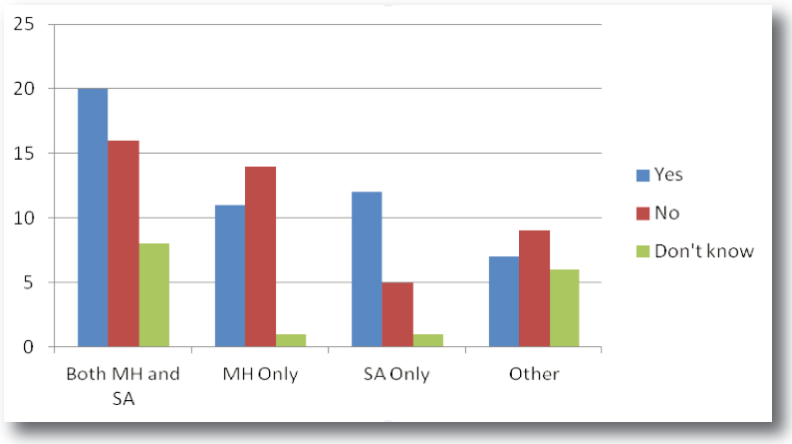
Type of Organization for Routine Sharing of Patient Information for Care Coordination (n=110)
Provider Focus Groups, June 2012

Dual focus programs exchange health information with medical exchange partners more so than their counterparts.



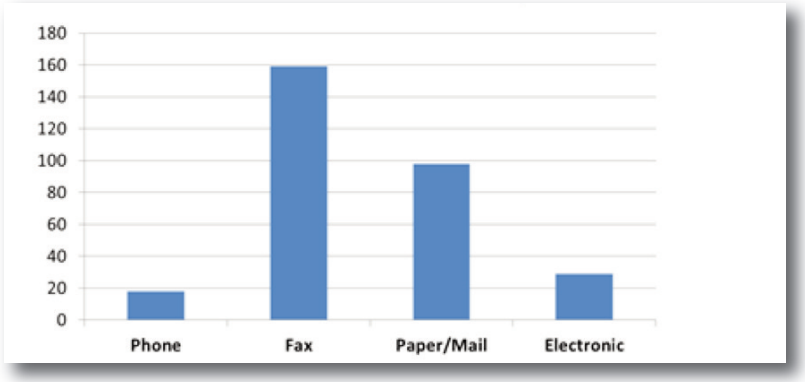
Data types shared between BH and Medical health providers (n=65)
BHO HIT Survey, February & March 2012

Mental health providers lag their counterparts in making patient information available to medical exchange partners.



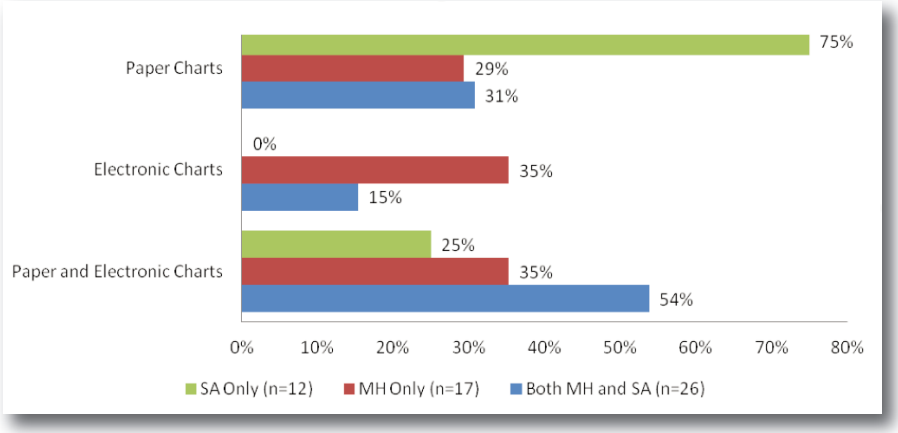
Sharing of Treatment Lists Between Providers Analyzed by Service Sector (n=65)
BHO HIT Survey, February & March 2012

Exchanging health records by fax is still overwhelmingly the method of transmission for behavioral health providers.



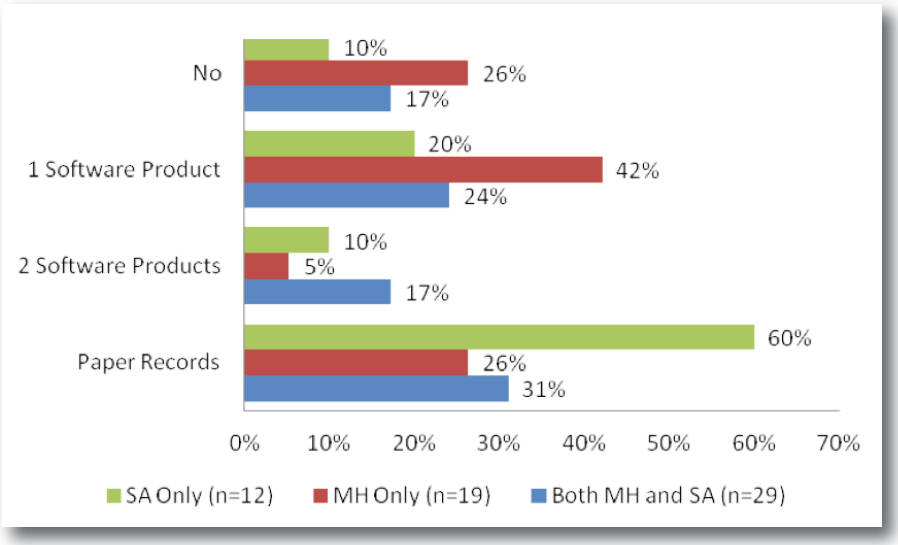
Top Four Means of Information Exchange (n=90)
Provider Focus Groups, June 2012

Electronic records and charts are becoming an operating standard for mental health providers, yet paper charts predominate among substance use treatment providers.



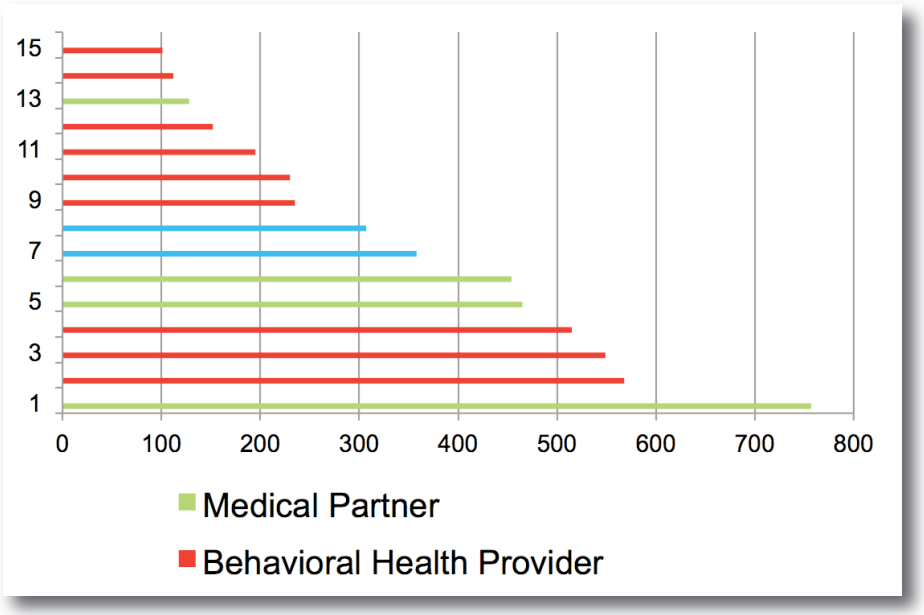
Patient Record Format by BH Service Sector (n=68)
BHO HIT Survey, February & March 2012

Increasingly, behavioral health providers rely on an EHR system to consolidate behavioral health and general medical patient records. Still, paper records persist as well.



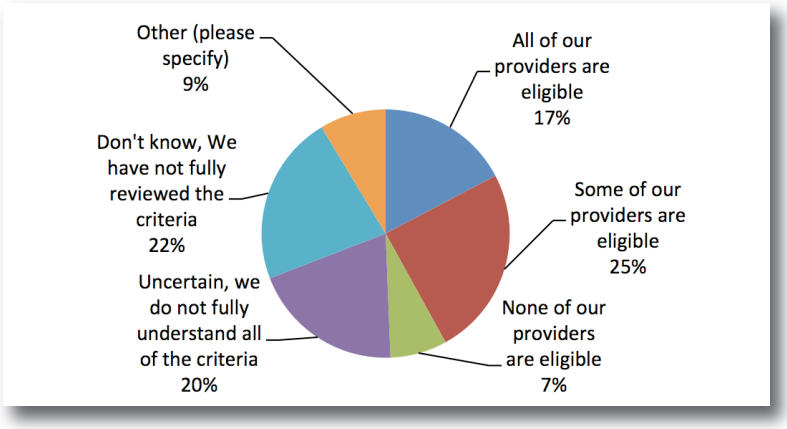
Type of Integration of BH and Primary Medical Care Records for BH Organizations (n=60)
BHO HIT Survey, February & March 2012

In the last year, behavioral health providers have distinguinshed themselves as early and avid adopters of secure email. The Direct environment can transmit both scanned documents (converted to a pdf) as well as electronic records generated from an EHR system.



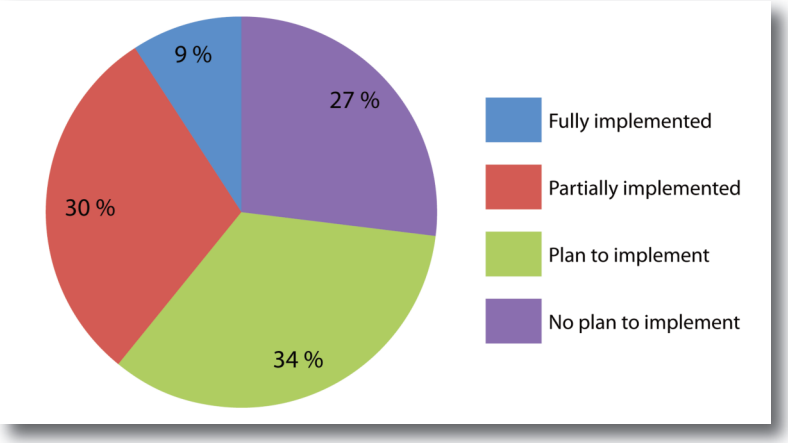
Top 15 Super Users of ILHIE Direct, October 2012 – March 2013
Number of Transactions
ILHIE Direct Registrant Report, March 2013

Most behavioral health providers (49%) have a clear understanding as to whether they and their staff qualify for incentive dollars to adopt EHR systems, and a significant portion (42%) do have providers that qualify for such dollars.

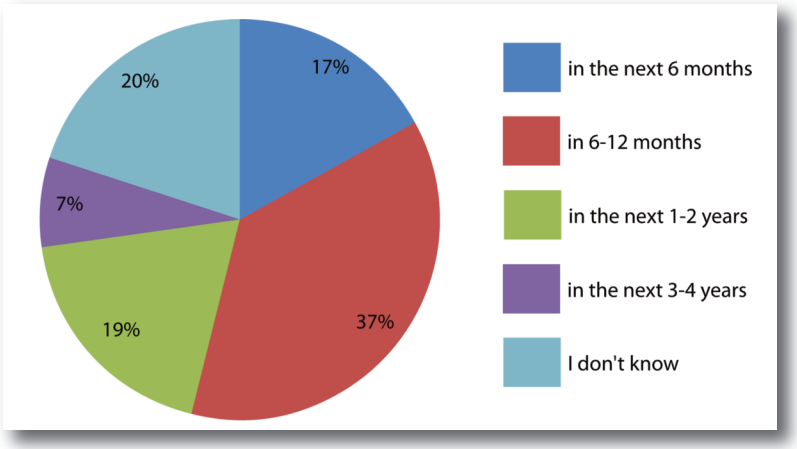


BH Organization Awareness of Provider Eligibility for EHR Incentive Programs (n=81)
BHO HIT Survey, February & March 2012

Many providers will have an EHR system and most will have one implemented by 2017.

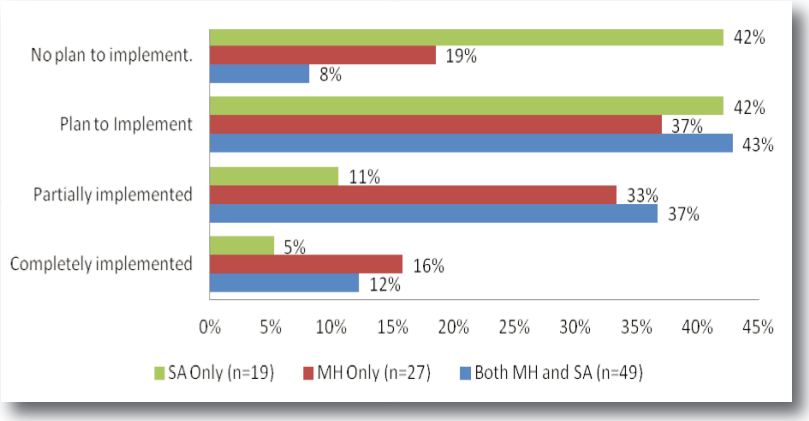


EHR Implementation Plans of BH Organizations (n=122)
BHO HIT Survey, February & March 2012



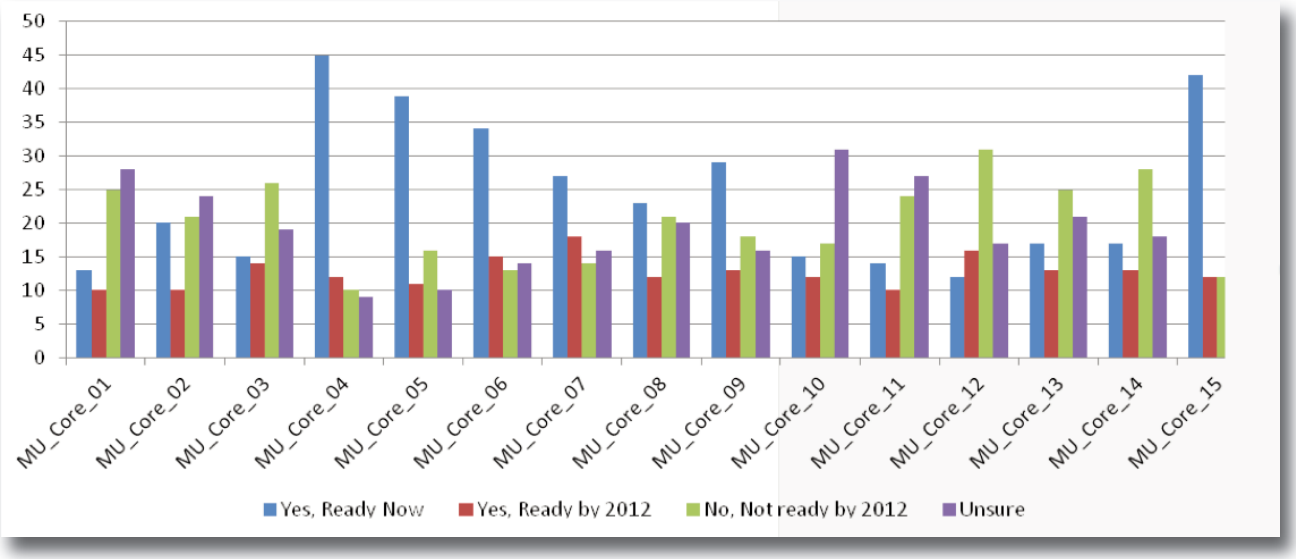
Implementation Timeline for BH Organizations Planning to Implement an EHR (n=41)
BHO HIT Survey, February & March 2012

Substance use treatment providers significantly lag their counterparts in adoption and the commitment to adopt EHR systems.



EHR Implementation by BH Organization Type (n=95)
BHO HIT Survey, February & March 2012

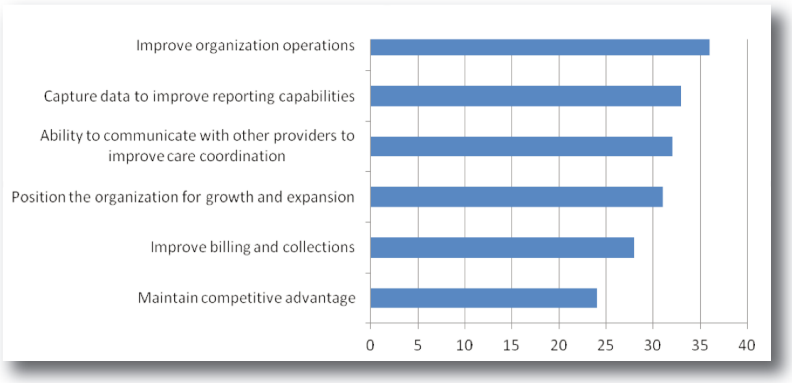
Behavioral health providers are currently capable of and have been in the process of implementing capabilities that have functionalities, both in terms of health IT and the practice scope, that allow them to participate in the incentive programs for Medicare and Medicaid.



Readiness for Meaningful Use Core Measures (n=76)
BHO HIT Survey, February & March 2012

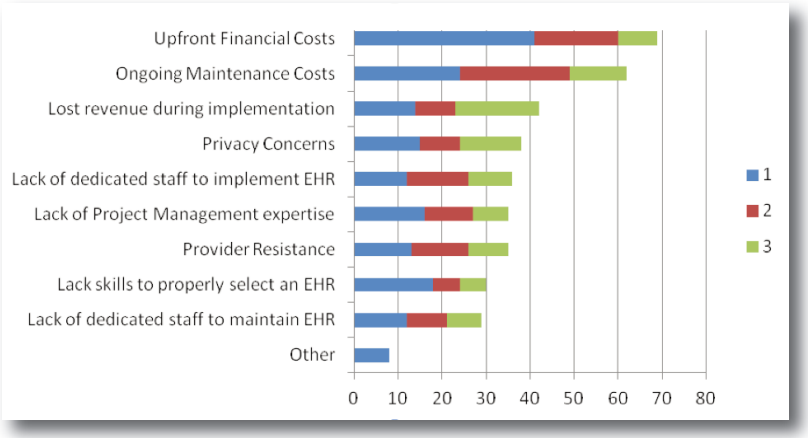
These providers are meeting national requirements for utilizing EHR systems and can meet measures associated with general medical services, such as the problem list (core 5), medication (core 6), allergies (core 7) and protecting health information (core 15).

Behavioral health providers do understand the benefits of utilizing EHR systems…



Expected Benefits of EHR Adoption by BH Organizations (n=39)
BHO HIT Survey, February & March 2012

…and understand the challenges.



Barriers to EHR Adoption and Implementation for BH Organizations in Illinois (n=98)
BHO HIT Survey, February & March 2012

Conclusion

The future of care coordination relies on an integrated, statewide health information exchange where all providers, especially behavioral health providers, can exchange records electronically to support a system dedicated to patient-centered care and instantaneous consultation across practice environments to improve patient health outcomes.

Behavioral health providers are actively adopting and implementing EHR systems, collecting incentive funding and have become top users of ILHIE Direct, a secure email service, to exchange health records electronically. These results show that behavioral health providers are pacing closely in the adoption of EHR systems to their medical counterparts. Last year, 39% of survey participants were using an EHR system and an additional 34% planned to implement one. At the same time, 42% of medical providers had one, and this year that percentage grew to 70%.

Remarkably, behavioral health providers can meet meaningful use standards, which has made them eligible for incentive funding. Furthermore, they can meet standards on health information that is critical across practice areas, such as medication, problem lists and allergies.

These survey results also reveal that the transition to electronic records and exchange is ongoing and impacts providers differently, depending on the services that they provide and the regulatory environment in which they operate. Dual focus programs lead the pack in adopting EHR systems; while substance use treatment providers trail all counterparts in adopting EHR systems and making a commitment to HIT. As a group, behavioral health providers exchange most frequently with medical providers, yet continue to rely on the fax machine to transmit information. Mental health providers are least inclined to make records available to medical partners.

In both surveys, substance use treatment providers represent the smallest group of respondents. Additional investigation into the capabilities and interests of substance use treatment providers can shed light on the potential of their integration in the health information exchange and care coordination in general.

Much progress has been made by behavioral health providers in the last two years and sustaining this progress will involve publicizing the ease of health IT and the HIE and reaching out to specialty providers, such as substance use treatment providers.

About the Surveys

The findings identified in this Case Studies Data derive from two surveys conducted in 2012. In February and March, the Behavioral Health Work Group of the ILHIE Advisory Committee surveyed 700 behavioral health organizations on HIT readiness. This universe included state funded and licensed mental health and substance use treatment providers as well as the full membership of the Illinois Psychiatric Society. This survey was conducted via email involving 54 questions and achieved an 18% response rate of 128 providers participating. Participants were 41% combined mental health and substance use treatment programs, 23% mental health programs, 15% substance use treatment and 21% other. Survey results are weighted towards providers on email. Geographic representation covered both urban and rural areas with 51% of organizations providing services in urban areas, 33% in rural areas and 16% in both areas. Capabilities of substance use treatment providers require further investigation in light of a smaller representation.

In June, providers were surveyed at five large-format focus groups that took place across Illinois as part of the Illinois Behavioral Health Integration Project. All state licensed and funded behavioral health providers were invited to the focus groups. Two focus groups were held in Chicago and the remaining three were held one each in Rockford, Springfield and Carterville. This survey involved the distribution of hard-copy questionnaires during the focus groups; of 161 individuals in attendance, 120 completed the survey for a 75% response rate. Participants included 36% dual focused programs (mental health and substance abuse); 34% mental health organizations and 11% substance abuse treatment and the remaining 19% included some mental health programs at medical providers and other programs for youth, community services and the courts. This survey does reflect a bias towards providers with HIT capabilities as some 96% of attendees had or were in the process of implementing an EHR system.

Acknowledgements

ILHIE gratefully acknowledges the Behavioral Health Work Group for their leadership role in ensuring the participation of behavioral health providers in the HIE. The Chicago Health Information Technology Regional Extension Center (CHITREC) conducted the analysis of both surveys. ILHIE thanks CHITREC for their work and partnership on this effort.

Author

Dia Cirillo is the author of this publication and served as the project director of the Illinois Behavioral Health Integration Project.

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